Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

J T DILGER JR MD
6718 MONTAY BAY DRIVE
SPRING TX 77389

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-1182-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Designated Doctor Exam faxed 3/30/11…Designated Doctor Exam Return to Worked faxed 3/30/11…Designated Doctor Exam Extent of Injury faxed 10/27/11"

Amount in Dispute: $1,350.00 + interest

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response for consideration to this dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 28, 2011	99456-NM-W5 99456-RE-W8	$350.00 $500.00	$850.00
October 19, 2011	99456-RE-W6	$500.00	$500.00
TOTAL		$1,350.00 + interest	$1,350.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §134.130 sets out the procedures for Interest for Late Payment on Medical Bills and Refunds.

2. 28 Texas Administrative Code §133.240 sets out procedures for medical payment and denials
3. Texas Labor Code §413.019 sets out procedures for Interest Earned for Delayed Payment, Refund, or Overpayment regarding medical services and fees.
4. Texas Labor Code §401.023 sets out procedures for computation of Interest or Discount Rate.
5. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
6. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 23, 2011
   - 1 – (A1) – Claim/Services denied.
   - 1 – (X737) – Bill has been cancelled

Issues

1. Is the respondent's denial adjustment reason codes supported?
2. What is the Maximum Allowable Reimbursement (MAR) for CPT Codes 99456-WP-NM, 99456-RE-W8 and 99456-RE-W6?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent denied the billing with reason code "1 – (A1) – Claim/Services denied" and "1 – (X737) – Bill has been cancelled." The respondent did not clarify or otherwise address or uphold the 1 – (A1) or 1 – (X737) claim adjustment codes upon receipt of the request for reconsideration or in the dispute resolution response, the Division will review the billing per the applicable Division rules and fee guidelines in 28 Texas Administrative Code §134.204 with the review of supporting documentation.

   The Texas Labor Code §408.0041 states in (h)(1): (h) The insurance carrier shall pay for: (1) an examination required under Subsection (a) or (f) and the Texas Labor Code §408.0041 states in (a)(1)(2): (a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any questions about: (1) the impairment caused by the compensable injury; (2) the attainment of maximum medical improvement.
2. The requestor billed the amount of $350.00 for CPT Code 99456-WP-MN regarding a Designated Doctor Examination for the injured worker not being at Maximum Medical Improvement (MMI), therefore no Impairment Rating was performed. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. The requestor also billed the amount of $500.00 for CPT code 99456-RE-W8 for a Return to Work (RTW) examination. Review of the documentation supports the services billed. Per 28 Texas Administrative Code §134.204(i)(2)(A) & (k), the Maximum Allowable Reimbursement (MAR) for the Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examination is $500.00. The combined MMI/RTW-EMC MAR is $850.00. Documentation and explanation of benefits dated September 23, 2011 received from the respondent via facsimile on April 25, 2011 indicates that the insurance carrier paid $0.00 on the services in dispute. The requestor also billed the amount of $500.00 for CPT code 99456-RE-W6 for an Extent of Injury Examination for date of service October 19, 2011. Review of the narrative documentation supports services rendered as billed. Per 28 Texas Administrative Code §134.204(i)(2)(A) and (k), the Maximum Allowable Reimbursement (MAR) for the 1st Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examination is $500.00. Copies of explanation of benefits were not submitted for review for this CPT code. CPT code 99456-RE-W6 will therefore be reviewed per the applicable Division rules and fee guidelines.
3. The respondent has previously reimbursed the requestor the amount of $0.00 for CPT Codes 99456-NM-W5 and 99456-RE-W8. In accordance with 28 Texas Administrative Code §134.204, the appropriate amount due for CPT Codes 99456-NM-W5 and 99456-RE-W8 is $850.00. The respondent has previously reimbursed the requestor the amount of $0.00 for CPT Code 99456-RE-W6. In accordance with 28 Texas Administrative Code §134.130, the appropriate amount due for CPT Code 99456-RE-W6 is $500.00. Therefore the amount of $1,350.00 is recommended for payment.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,350.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,350.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 23, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.